TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Gregory S. Goldsmith, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-17-0128-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 16, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Goldsmith reviewed x-rays of the wrist and shoulder … ***A payment in the amount of $1150 was received, leaving a balance of $150.00.***"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor, as designated doctor, indicated in his DWC60 packet that he performed xray testing to the wrist and shoulder in order to determine the IR. He then billed for each with code 99456WP. Texas Mutual declined to issue payment absent documentation of the xray testing and absent documentation explaining why the testing is reimbursable apart from the MAR for MMI and IR."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 24, 2016	X-rays	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 891 – No additional payment after reconsideration.
- CAC-18 – Exact duplicate claim/service.
- 878 – Appeal (request for reconsideration) previously processed. Refer to Rule 133.250(h).

Issues

Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code CAC-16 – "CLAIM/SERVICE LACKS INFOMRATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION;" and 225 – "THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION." In his position statement, the requestor indicates that the services in dispute are for x-rays of the left wrist (2 views) and left shoulder (3 views). The requestor billed these services with procedure code 99456-WP.

28 Texas Administrative Code §134.204(j)(5) provides that

> If the examination for the determination of MMI and/or the assignment of IR requires testing that is not outlined in the AMA Guides, **the appropriate CPT code(s) shall be billed** and reimbursed in addition to the fees outlined in paragraphs (3) and (4) of this subsection.

The division finds that procedure code 99456-WP is not the appropriate CPT code for either a 2-view x-ray of the left wrist or a 3-view x-ray of the left shoulder. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	October 7, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.